

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 001148	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/14/2014
NAME OF PROVIDER OR SUPPLIER WOOD RIDGE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 17650 GENERATIONS DR SOUTH BEND, IN 46635		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This survey was for the Investigation of Complaint IN00145421.</p> <p>Complaint IN00145421-Unsubstantiated due to lack of evidence.</p> <p>Survey date: April 14, 2014</p> <p>Facility number: 001148 Provider number: N/A AIM number: N/A</p> <p>Survey team: Honey Kuhn, RN</p> <p>Census bed type: Residential: 66 Total: 66</p> <p>Census payor type: Medicaid: 51 Other: 15 Total: 66</p> <p>Sample: N/A</p> <p>Wood Ridge Assisted Living was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00145421.</p> <p>Quality Review 04/14/14 by Lisa McColly</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE